(45)

No. 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON,

Petitioner,

vs.

HAROLD GLUCKSBERG, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE AMERICAN SUICIDE FOUNDATION, *AMICUS CURIAE*, SUPPORTING REVERSAL

ELLEN H. MOSKOWITZ
Associate for Law
THE HASTINGS CENTER
Counsel of Record for The American Suicide Foundation
Amicus Curiae
255 Elm Road
Briarcliff Manor, New York 10510
(914) 762-8500

EDWARD R. GRANT
Herndon, Virginia
JOHN F. CANNON
New York, New York
Of Counsel.

November 12, 1996

HIPP

TABLE OF CONTENTS

PAGE

PAGE

TABLE OF AUTHORITIES

PAGE

OTHER AUTHORITIES

PAGE

PAGE

PAGE

PAGE

PAGE

IN THE

Supreme Court of the United States

October Term, 1996

No. 96-110

STATE OF WASHINGTON,

Petitioner,

v.

HAROLD GLUCKSBERG,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE AMERICAN SUICIDE FOUNDATION, AMICUS CURIAE, SUPPORTING REVERSAL

This brief is in support of reversal and is filed pursuant to Rule 37.3 with the consent of all parties.

Interest of *Amicus Curiae*

The American Suicide Foundation (ASF) is a nonprofit organization dedicated to the prevention and study of suicide. ASF was founded in 1987 by mental health professionals, business and community leaders, and people who had lost loved ones to suicide. Its activities include educational efforts for health professionals and the public on the recognition and treatment of depressed and suicidal individuals, a program of individual grants and postdoctoral fellowships to attract talented scientists into the field, and an institutional grant program to help major medical centers — such as Harvard Medical School, Columbia University College of Physicians & Surgeons, University of Pittsburgh Medical School, Emory University School of Medicine, and University of Texas Medical School — become important centers

for suicide research and treatment. The ASF's Scientific Advisory Committee is comprised of the leading experts on suicide in the country. Its Executive Director, Herbert Hendin, M.D., is an authority on the psychiatric and social aspects of suicide.

ASF has embraced the mission to improve care for people who are terminally or chronically ill, for without good care they are particularly vulnerable to suicide. ASF opposes the legalization of physician-assisted suicide which would not improve the care of seriously ill patients, but rather foster suicides that are preventable.

The decision below of the Ninth Circuit, *Compassion in Dying* v. *Washington*, 79 F.3d 790 (9th Cir 1996) if affirmed, would thoroughly vitiate ASF's efforts.[1] In order to preserve a legal environment in which it will be able to advance the interests of terminally and chronically ill patients in general and those of suicidal patients in particular, ASF respectfully urges the Court to reverse the decisions below.

Summary of Argument

The court gives constitutional significance to the judgment that a terminally ill person's wish to commit suicide is presumptively the autonomous expression of an informed and deliberate assessment of the value of his or her own life, but that a physically healthy person's wish to commit suicide need not be so regarded.[2]

---

[1] ASF would be no less adversely affected by an affirmance in the case from the Second Circuit (No. 95-1858), *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), that is being considered in tandem with the instant case, and urges that it also be reversed. Although both decisions make the same erroneous psychosocial assumptions, they appear more explicitly in the Ninth Circuit's decision.

[2] The above distinction was drawn by the court in the context of its effort to rely on the *dictum* in *Planned Parenthood of Southeastern Pa.* v. *Casey* 505 U.S. 833, 851 (1992), but limit its reach, 79 F.3d at 820-821, a goal which the prior panel majority considered logically impossible, 49 F.3d at 590-591.

No sound scientific or clinical basis exists for distinguishing suicidal patients with terminal conditions from other suicidal patients; treatable, reversibie mental disorders, usually of a depressive nature, characterize both. Both groups are ambivalent about the desire to die; both suffer from extreme anxiety and cognitive impairments; both have excessive needs for control, most dramatically expressed by controlling the time and place of their death. In both groups depression interferes with their decision-making ability.

The court is also incorrect in its assertion that "terminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family and friends." 79 F.3d at 821. The clinical literature documents that terminally ill persons, including those who have expressed the desire to die, are usually able to spend their last days in meaningful and pleasurable interchange with family and friends.

Moreover, although adults with terminal illness who seek lethal drugs from their physicians are as a group characterized by treatable, reversible mental illness, the same is not true of patients with terminal illness who decide to forgo medical procedures near the end of life. In other words, there is a clinical difference which parallels the ethical distinction between these two types of patient-care situations, a clinical difference which the court ignored as it rejected the ethical distinction. 79 F.3d at 829, n.102.

The court's opinion also rests on erroneous presumptions regarding the ability of the medical profession and the law to limit the exercise of this new-found constitutional right only to those patients who are terminally ill, of sound mind, free of depression or other psychological illness, and unswayed by duress or other undue influence. 79 F.3d at 826-827, 833. These criteria presume the ability on the part of the physician to make the necessary assessments on an objective basis. However, case studies from the United States and the Netherlands demonstrate that a physician's willingness to assist in suicide is itself a powerful influence on the decision of a patient with suicidal tendencies, and that such

physicians are not capable of making an objective assessment of the impact their attitude has had upon the patient.

In the Netherlands, despite legal and professional guidelines designed to ensure that assisted suicide and euthanasia takes place only upon the decision of a competent patient free of duress, the attitudes and decisions of physicians—particularly in presenting euthanasia as a reasonable option to patients—play a decisive role. The Dutch experience demonstrates that physicians are ill-suited, in an environment tolerant of assisted suicide and euthanasia, to keep such practices within prescribed limits. The Dutch experience also demonstrates the futility of reliance on legal regulations to maintain such limits. The guidelines established by Dutch courts have not been followed; the practice of euthanasia has moved from the terminally ill to the chronically ill, from cases of untreatable physical illness to cases of treatable psychological distress, and from voluntary euthanasia to involuntary euthanasia. Indeed, the majority of cases in which doctors actively cause or hasten death occur without the patient's explicit request. Legalization of assisted suicide and euthanasia has also impaired the treatment of depressed suicidal patients by making the distress of such patients a legitimate reason for their dying.

That this should occur in a nation with a strong tradition of adherence to rules, and in a medical profession of great technical competence and noted dedication to individual patients, demonstrates the corrosive effects of removing the barriers against physician participation in killing. Depriving the states of the power to prevent physician-assisted suicide among terminally ill patients will deprive them of the ability to afford those patients the protection and help that are afforded suicidal patients who are not terminally ill.

ARGUMENT

I. THE DECISION BELOW ERRS IN ASSUMING THERE EXISTS A SOUND SCIENTIFIC OR CLINICAL BASIS FOR DISTINGUISHING SUICIDAL PATIENTS WITH TERMINAL CONDITIONS FROM SUICIDAL PATIENTS WITHOUT TERMINAL CONDITIONS; TREATABLE, REVERSIBLE MENTAL DISORDERS CHARACTERIZE BOTH.

In 25 percent of all suicides, problems derived from a physical illness play an important role.[3] The percentage for whom illness is important increases with age, rising from 13 percent in those under 39 when they kill themselves to 70 percent in those over 60.[4] However, like other suicidal individuals, patients who wish to kill themselves during a serious illness are characteristically suffering from a treatable mental illness, most commonly a depressive condition.[5] A comprehensive 1995 review of decades of studies on suicide and physical illness concludes, "there is little evidence to support the notion that chronic or terminal illness is an independent risk factor for suicide, outside the context of depression or other mental disorder.[6] Although physical pain or social isolation, including lack of family support, contribute to the wish for death, none is as significant as depression, which researchers have found to be the only predictor

---

[3] T.B. Mackenzie & M.K. Popkin, *Medical Illness and Suicide, in Suicide Over the Life Cycle* (S.J. Blumenthal & D.J. Kupfer eds., 1990).

[4] Id.

[5] J.H. Brown et al., *Is it Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psychiatry 208 (1986); H.M. Chochinov et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185 (1995); D.C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities*, 2 Issues in Law & Med 147, 160 (1993).

[6] E.R. Mościcki, *North American Perspectives: Epidemiology of Suicide, in Suicide and Aging: International Perspectives* 137 (J.L. Rearson & Y. Conwell eds., 1995).

of the desire for death even given the presence of these other factors.[7]

Strikingly, the overwhelming majority of the patients who are terminally ill do not attempt or commit suicide.[8] Some may voice suicidal thoughts in response to transient depression or severe pain, but these patients usually respond well to treatment for depressive illness and pain medication, and are grateful to be alive.[9]

Depression and the other mental disorders motivating suicidal impulses and acts are treatable and reversible, and when these mental illnesses are addressed with sensitivity and clinical expertise, the thoughts of suicide ordinarily subside.[10] Unfortunately, depression is also underdiagnosed and often inadequately treated. Even though most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of depressive illness or even if they do, to give inadequate treatment.[11]

---

[7] E.J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 The Lancet 1805 (1996); H. Hendin & G.L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am J. Psychiatry 143 (1993).

[8] E. Robins et al., *Some Clinical Considerations in the Prevention of Suicide Based on a Study of 134 Successful Suicides*, 49 Am J. Pub. Health 888 (1959); C.P. Seager & R.S. Flood, *Suicide in Bristol*, 11 Br. J. Psychiatry 919 (1965).

[9] Hendin & Klerman, *supra* note 7 at 143-145; Clark, *supra* note 5 at 160-161.

[10] NIH Consensus Development Panel on Depression in Late Life, *Diagnosis and Treatment of Depression in Late Life*, 268 JAMA 1018, 1024 (1992); New York State Task Force on Life and the Law, *When Death is Sought*, 175-177 (1994); A.J. Roth & J.C. Holland, *Treatment of Depression*, 14 Primary Care in Cancer 24 (1994).

[11] NIH Consensus Development Panel on Depression in Late Life, *supra* note 10 at 1021-22.

People are apt to assume that seriously or terminally ill patients who wish to end their lives are different from those who are otherwise suicidal. But an early reaction of some patients to the knowledge of serious illness and possible death, is terror, depression and a wish to die. Such patients are not different from patients who react to other crises in their lives by a desire to end the crisis by ending their lives.[12]

Although the fear of death itself is not usually given by patients as a reason for requesting assisted-suicide, clinicians treating such patients find that many displace anxieties about death onto the circumstances of dying — loss of dignity, pain, being dependent on others, or the unpleasant side effects resulting from medical treatments. Focusing on, or becoming enraged at, the process distracts from the fear of death itself.[13]

For example, Tim, a young professional in his early thirties who had acute myelocytic leukemia, was referred for psychiatric consultation.[14] With medical treatment, Tim was given a 25 percent chance of survival; without it, he was told, he would die in a few months. An ambitious executive whose focus on career success had led him to neglect his relationships with his wife and family, Tim was stunned. His immediate reaction was a desperate, angry preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment. Tim's anxieties about the painful circumstances that would surround his death were understandable, but all his fears about dying amplified them. Once Tim could talk about the possibility or likelihood of his dying — what separation from his family and the destruction of his body meant to him — his desperation subsided. He used the remaining months of his life to

---

[12] Hendin & Klerman, *supra* note 7 at 143-145.

[13] H. Hendin, *Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience*, 25 Suicide and Life-Threatening Behavior 193 (1995).

[14] *Id.*

become closer to his wife and parents. Two days before he died, Tim talked about what he would have missed without the opportunity for a loving parting.

Like Tim, the vast majority of those who request assisted suicide or euthanasia are motivated primarily by dread of what will happen to them rather than by current pain or suffering.[15] Patients do not know what to expect and cannot foresee how their conditions will unfold as they decline into death. Facing this ignorance, they fill the vacuum with their fantasies and fears. When these fears are dealt with by a caring sensitive physician, the request for death usually disappears.

Along with these disorders of depression and anxiety, suicidal patients, regardless of their physical condition, are prone to impose conditions on life: I won't live ... "without my husband," or "if I lose my looks, power, prestige or health," or "*if I am going to die soon.*" They are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control.[16]

This rigidity reflects the impaired thought processes and irrationality that characterize the depressed state of those who are suicidal whether they are terminally ill or not. Cognitive functioning is impaired by unrealistically low self-regard, ideas of deprivation and rejection often in the face of overt demonstrations of affection, and a tendency toward self-blame with no logical basis.[17]

---

[15] P. Admiraal, *A Physician's Responsibility to Help a Patient Die, in The Good of the Patient: The Good of Society*, (1992).

[16] Hendin, *supra* note 13 at 193.

[17] A. Beck, *Thinking and Depression, in Arch. Gen. Psychiatry* 324 (1963); D.C. Clark et al., *Intellectual Functioning and Abstraction Ability in Major Affective Disorders* 26 (1985); L. Ganzini et al., *Depression, Suicide, and the Right to Refuse Life-Sustaining Treatment*, 4 J. Clinical Ethics 337, 338 (1995).

One particular cognitive impairment typically found in depressed suicidal patients is the tendency to develop a distorted and overly negative perception of their physical condition, while remaining unaware of their depression. This lost understanding can sometimes become so intense as to lead to an erroneous belief that they are ill and dying, when in fact they are not. For example, in two separate community-based studies of elderly persons who died by suicide, there were more persons who killed themselves because they mistakenly believed they had cancer, than there were persons who died with cancer or any other terminal illness.[18]

Statements such as "I don't want to be a burden to my family" or "My family would be better off without me" are also often made by those requesting assisted suicide or euthanasia. Such expressions reflect depressed feelings of worthlessness or guilt and may be a plea for reassurance. However, such statements are also classic indicators of suicidal depression in patients who are in good physical health. Whether healthy or terminally ill, these patients need assurance that they are still wanted; they also need treatment for their depression.[19]

Another characteristic of suicidal patients, regardless of their state of physical health, is a sometimes calm demeanor that masks their depressed and anxious mental state.[20] In particular, some patients who are depressed and suicidal appear less depressed and calm after resolving to end their lives. It is coping with the circumstances of life that agitates and depresses these patients; that they find relief in the decision to die is hardly an indication that the decision is appropriate.

The ambivalent and variable nature of the wish to die also characterizes both suicidal patients who are terminally ill and

---

[18] Y. Conwell et al., *Suicide and Cancer in Late Life*, 41 Hosp. & Community Psychiatry 1334, 1337-38 (1990); G.K. Murphy, *Cancer and the Coroner*, 237 JAMA 786, 788 (1977).

[19] Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 Duquesne L.Rev. 285 (1996).

[20] Clark, *supra* note 5 at 155-56.

suicidal patients who are not terminally ill.[21] For example, in one study of patients with terminal illness, interviews were conducted two weeks after they had expressed the wish to commit suicide, and already two-thirds showed a significant decrease in the extent of the desire to die.[22] If the doctor fails to recognize the ambivalence that underlies the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.[23]

An assisted-suicide case that Compassion in Dying, a corporate plaintiff in the district court below, 79 F.3d at 794, n.2, regards as a model, was the subject of a cover story in the *New York Times Magazine* in 1993. The case captures the coercive effect on an individual, made vulnerable by her physical and mental condition, of being surrounded by those who did not understand, or choose to hear, her ambivalence.[24]

The story describes the suicide of Louise, a Seattle woman whose death was arranged by her doctor and the Reverend Ralph Mero, the head of Compassion in Dying. Louise expresses conflicting wishes — to live and to die — but only for death does she find support. Those around Louise became part of a network

---

[21] Chochinov et al., *Desire for Death in the Terminally Ill*, *supra* note 5 at 1185-1191.; Jensen and Petty, *The Fantasy of Being Rescued*, 27 Psychoanalytic Q. 327 (1958); H. Hendin, *Suicide in America* 2d Ed. (1995).

[22] Chochinov et al., *supra* note 5 at 1185-1191.

[23] H. Hendin, *Selling Death and Dignity*, 25 Hastings Center Report 19 (1995). This characteristic ambivalence has been studied in those rare cases of survival following suicidal jumps from high bridges. According to one jumper who survived a leap from the Golden Gate Bridge, "From the instant I saw my hand leave the railing, I knew I wanted to live. I was terrified out of my skull." After waking up in the water he remembered, "I was screaming, 'Oh, God, save me! Oh, God, I want to live.'" Leo Rangell, *The Decision to Terminate One's Life: Psychoanalytic Thoughts on Suicide*, 18 Suicide and Life-Threatening Behavior 28, 30-31 (1988).

[24] L. Belkin, *There's No Simple Suicide*, N. Y. Times Mag. November 14, 1993, at 50.

pressuring her to stick to her decision and to carry it out in a timely manner. Louise is shown to be clearly frustrated by not having someone to talk to who had no stake in persuading her to stick to her initial decision. For example, at one point Louise, now looking terrified, tells her mother "I just feel as if everyone is ganging up on me, pressuring me. I just want some time." Individually and collectively, those involved engender a terror in Louise that she bears alone, while they reassure each other that they are sensitively engaged in gratifying her last wishes. The end of her life does not seem like death with dignity, nor is there much compassion in the way Louise was helped to die.[25]

Finally, it must be underscored that the specific desire to be put to death by one's doctor can be found in suicidal patients both with and without terminal illness.[26] Therapists who are unaware of this assume that patients who have sought their help will see them as saviors, when actually they have been cast in the role of executioner, with the patient typically fantasizing closeness or union with the doctor through death.[27]

The prominent assisted-suicide case involving the internist Timothy Quill, a plaintiff in *Quill v. Vacco*, and his patient, Diane, illustrates the hazards of physicians offering lethal drugs to suicidal patients with serious physical illness, rather than the treatments and interventions ordinarily indicated for suicidal patients.[28] The case involved oversights regarding the indicators of Diane's depression, shared reunion fantasies, and the physician's apparently one-sided encouragement of his vulnerable

---

[25] Hendin, *supra* note 23 at 21.

[26] S. Asch, *Suicide and the Hidden Executioner*, Int'l Rev. Psychoanalysis 51 (1980); H. Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* (1996).

[27] H. Hendin, *Psychodynamics of Suicide With Particular Reference to the Young*, 148 Am. J. Psychiatry 1150 (1991).

[28] T. E. Quill, *Death and Dignity - A Case of Individualized Decision Making*, 324 N. Eng. J. Med. 691 (1991); T.E. Quill, *Death and Dignity: Making Choices and Taking Charge* (1993).

patient's suicidal urges, both by what he said, and by what he failed to say and do.

Diane, who suffered from depression and alcoholism through much of her adult life, developed acute leukemia. She reacted with rage and despair, which shortly turned to thoughts of suicide. Quill notes that he responded to her emotional turmoil, as well as to her decision to refuse chemotherapy (with a 25% chance of success), made shortly after the diagnosis, by joining together with her to lament "her tragedy and the unfairness of life." When Diane asks for his help in committing suicide, after justifying it by her need to be in control and by her conviction that she would die during treatment for leukemia, Quill never questions her insistence on total control, an impossible demand in the face of serious illness, or sees this as potentially an aspect of depression, not simply a reasonable response. Moreover, he does not challenge her firm insistence that treatment would fail, which she had no way of knowing.

Although initially Quill tells Diane that he cannot take part in her suicide, he appears to have conveyed to her just what he later communicated to the general public: that her "request made perfect sense" to him. Quill ultimately responds to Diane's suicidal wishes by referring her to the Hemlock Society, which he describes to her as "helpful," and eventually by prescribing for her the barbiturates that the Society recommended she use. When Diane says goodbye to Quill, shortly before her death, she promises "a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons shining in the sunset." Quill concluded his account of the case in the *New England Journal of Medicine* by wondering whether he "will see Diane again, on the shore of Lake Geneva at sunset, with dragons swimming on the horizon."[29]

---

[29] Analysis of this case is taken from H. Hendin, *supra* note 26 at 125-128. See also P. Wesley, *Dying Safely*, 8 Issues in Law and Med. 467 (1993).

II. ALTHOUGH PATIENTS WITH TERMINAL ILLNESS WHO SEEK LETHAL DRUGS FROM THEIR PHYSICIANS ARE VIRTUALLY CERTAIN TO HAVE TREATABLE, REVERSIBLE MENTAL ILLNESS, THE SAME IS NOT TRUE OF PATIENTS WITH TERMINAL ILLNESS WHO DECIDE TO FORGO MEDICAL PROCEDURES NEAR THE END OF LIFE.

The Ninth Circuit found the state's interest in physician-assisted suicide to be no different from its interest in a patient's refusal of treatment. 80 F.3d at 828, 837. The merits of any ethical distinction will be argued in other briefs, but the clinical evidence provides a basis for distinguishing the two situations. Mental competence distinguishes the two groups, as research is beginning to demonstrate.[30] This is not to say that some people who refuse treatment are not suicidally depressed, but that suicidal depression is not characteristic of the group.

This research is confirming years of clinical impressions that neither mental impairment nor preoccupation with suicide is characteristic of the choice by seriously ill patients to forgo treatments of uncertain effectiveness that are nonetheless likely to cause intense burdens, such as pain, bodily invasion, and the emotional suffering that can accompany physical isolation during a course of treatment in a hospital, as opposed to being at home with loved ones.[31] Under these circumstances, the choice to forgo medical interventions is not suicide, but a judgment about how to live before one dies.

---

[30] L. Ganzini et al., *supra* note 17 at 338-339.; M. Lee & L. Ganzini, *Depression in the Elderly: Effect on Patient Attitudes Toward Life-Sustaining Therapy*, 40 J. Am. Geriatrics Soc'y 983 (1992); L. Ganzini et al., The Effect of Depression Treatment on Elderly Patients' Decisions Regarding Life-Sustaining Medical Treatment (unpublished paper).

[31] *See*, for example, C.M. Saunders, *The Last States of Life, in Hospice Care: Principles and Practice* 5-11 (C.A. Corr & D.M. Corr eds., 1983); Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* (1992); Kenneth P. Cohen, *Hospice: Prescription for Terminal Care* (1979).

The lower court's position is linked to its failure to recognize that, legally and medically, the right to forgo treatment is rooted in our abhorrence of the violence inherent in forcing medical interventions on unwilling, competent adults, regardless of their physical condition, not in social acceptance of suicide or indifference to the suicidal acts of the physically ill. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, at 277, 280 (1990). The strength of the competent patient's right to refuse unwanted treatment is not a function of physical condition. Under principles of informed consent, competent adult patients, whether or not they are terminally ill, can refuse any treatment for any reason.[32]

III. AS ILLUSTRATED BY THE EXPERIENCE OF THE NETHERLANDS, PHYSICIANS CANNOT BE RELIED UPON TO IDENTIFY THOSE PATIENTS WHO WOULD BE CONSTITUTIONALLY ENTITLED TO ASSISTANCE IN KILLING THEMSELVES, AND TO DISTINGUISH THEM FROM PATIENTS WHO WOULD NOT HAVE THE RIGHT TO SUCH ASSISTANCE.

A. The Decision Below Relies Upon the Ability of Physicians to Make Objective Assessments Regarding the Nature of a Patient's Desire for Death that Physicians Willing to Cooperate in Assisted Suicide Are Not in a Position to Make.

The Ninth Circuit stated that decisions by terminally ill patients to end their lives do not really constitute suicide, nor is helping them to do so "assisted suicide." 79 F.3d at 802, n.5, 824. So long as the patient is of sound mind, free of depression or other psychological illness, and unswayed by duress or other

[32] G.A. Annas, *The 'Right to Die' in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 Duquesne L.Rev. 875, 876-77 (1996). That right may be limited under certain circumstances, such as the presence of a contagious disease like tuberculosis. *See also* A.M. Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 4 Ariz. St. L. J. 647, 656-58 (1984).

undue influence, *id.* at 826-827, 833, the court holds that he or she is merely exercising a constitutionally recognized "liberty interest in hastening one's own death." *Id.* at 816.[33]

However, as Point I of this brief demonstrates, this paradigm lacks a real world foundation. Individuals with severe illness who wish to kill themselves have the same clinical profile as other suicidal individuals. Both have mental disorders characterized by depression, extreme anxiety, and impaired cognition that render them vulnerable to the coercive influence of others.

There is another problem as well. The decisions and acts that the court's paradigm entails take place in clinical contexts which are subject to infinite variation, and the paradigm supposes that in each case the physician, after whatever consultation he may seek or may be mandated by the State, will be able to make several critical assessments.

In addition to ruling out that the terminally ill patient wishing to kill himself or herself has any mental disorder, the physician must be able to assess objectively the patient's understanding of the physician's role in shaping the patient's decision. A physician's willingness to assist in suicide in a particular case will likely follow from a determination that this is a reasonable course of action for that patient; by communicating this willingness, the physician will likely influence the patient's own determination, particularly if, as is most often the case, the patient has a depressed mental state that the physician simply missed. The physician must be able to make a similar objective assessment regarding the attitude and conduct of family members on the patient's decision.

If any of these assessments are made improperly—if the patient is depressed or if the physician's or family's attitudes have prompted or reinforced the desire for suicide—the patient's

[33] The Second Circuit disagreed with the Ninth Circuit that a "right to die" is an aspect of the liberty which the Due Process Clause protects, 80 F.3d at 723-725, but it came out in precisely the same place by also disagreeing with it over what constitutes "suicide." *Id.* at 729-730.

"choice" is not autonomous and there is no basis for granting constitutional protection to the physician's actions in causing death.

The Ninth's Circuit's confidence in the sound judgment of physicians notwithstanding, there is little reason to trust in the physician's ability to properly evaluate the patient's psychological state and the factors affecting it. The interactions described by Dr. Quill in his own account of the death of Diane (above, pages 11-12) suggest that doctors willing to assist in their patients' deaths become so closely entwined with their patient's decision that they forfeit the professional distance necessary to objectively assess their own potential influence on the patient's decision. The case of Louise (above, pages 10-11) illustrates not only the power of physicians to influence these decisions, but the role that family attitudes may play.

Furthermore, contrary to the Ninth Circuit's assumptions regarding the efficacy of statutory and professional guidelines to ensure the integrity of decisions for assisted suicide, 79 F.3d at 832-833, 837, these decisions and actions will occur in the zone of confidentiality between physicians and patients and as such, will remain largely beyond the reach of such regulation.[34] The experience of the Netherlands, a society with a strong legal tradition and a medical profession of great technical competence and noted dedication to individual patients, provides further proof of this reality.

[34] Daniel Callahan and Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 8-10 (1996).

B. The Experience of the Netherlands Demonstrates the Inability of Physicians, In an Environment Tolerant of Assisted Suicide and Euthanasia, to Make the Objective Assessments Necessary to Keep Such Practices within Prescribed Limits.

The Netherlands has not formally decriminalized assisted suicide or euthanasia.[35] Rather, in a series of court decisions,[36] in guidelines issued by prosecutors and the Royal Dutch Medical Association (KNMG), and recently in statute,[37] the Dutch have fashioned criteria under which doctors will not be subject to punishment for participating in physician-assisted suicide or euthanasia. The criteria reflect the same confidence in the ability of physicians to make the critical assessments and distinctions regarding the eligibility of patients for such measures that animates the decision of the Ninth Circuit.[38]

Three studies of the Dutch experience—by a British attorney and legal historian,[39] an American gerontologist,[40] and an

[35] Killing a person at his "express and serious request" is punished by Article 293 of the Dutch Penal Code; inciting or providing the means for another to commit suicide is prohibited by Article 294. John Keown, *Some Reflections on Euthanasia in the Netherlands, in Euthanasia, Clinical Practice and the Law* 193, 193-194 (Luke Gormally ed., 1994) ("Keown I"). *See also* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope, in Euthanasia Examined* 261 (1995) ("Keown II").

[36] Toleration of euthanasia is based on the principle of *force majeure*, or legal necessity, arising from a "conflict of duties" between the physician's responsibility to the law, which makes euthanasia illegal, and the responsibility to help a patient whose unrelievable suffering makes euthanasia necessary. Keown I, *supra* at 194-198; Carlos Gomez, M.D., *Regulating Death: Euthanasia and the Case of the Netherlands* 38 (1991).

[37] Henk Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. Med. Ethics 212, 214 (1994).

[38] *See* Gomez, *supra* at 21; 79 F.3d at 827.

[39] Keown I and Keown II, *supra.*

[40] Gomez, *supra.*

American psychiatrist[41]—have independently concluded that these guidelines are not only unenforced, but, as is likely to be the case for any proposed regulation of assisted suicide and euthanasia, unenforceable.[42] Most pertinent for purposes of this discussion is how the principle of voluntariness is compromised.

Under the Dutch guidelines, the patient must request euthanasia, and the request must be free and voluntary, informed, and without duress. In practice, however, the physician's role as arbiter of whether a patient's request is truly voluntary influences the decision. These requirements "do not prevent either the doctor or nurse from mentioning euthanasia to the patient as an option or even strongly recommending it."[43] Nor can they ensure that euthanasia is not chosen "out of ignorance or misunderstanding of one's situation."[44] Thus, while "the ideal commands that only patients may choose whether to exit this life via euthanasia, the reality of the practice seems to suggest that only physicians may actually open the door and, in some instances, may describe where the door is to patients who cannot clearly see it."[45]

The Van der Maas Survey—the official study of euthanasia commissioned by the Dutch government—revealed that more than half of Dutch physicians consider it appropriate to introduce the subject of euthanasia to their patients.[46] In a study of euthanasia done in Dutch hospitals, doctors and nurses reported that more requests for euthanasia came from families than from the patients themselves, and the investigators concluded that families, doctors, and nurses were involved in pressuring patients to accept

---

[41] Hendin, *supra* note 26.

[42] Gomez, *supra* note 21 at 121-122; Hendin, *supra* note 26 at 220; Keown II at 265-266, 286-287.

[43] Keown I, *supra* at 203.

[44] Gomez, *supra* note 7 at 104.

[45] *Id.* at 109.

[46] P.J. van der Maas, et al., *Euthanasia and other Medical Decisions Concerning the End of Life* 102, Table 9.7 (1992) (hereinafter *Survey*).

euthanasia.[47] These actions are presumably motivated by a feeling that the patient's situation is "hopeless;" however, such pressure effectively tells the patient that his or her life is not worth living, a message that has a powerful effect on a vulnerable patient's outlook and wishes.[48]

In one case, a woman who no longer wanted to care for her chronically-ill husband gave him a choice between euthanasia and admission to a nursing home. The patient, fearful of being cared for by strangers in an unfamiliar environment, chose euthanasia; the doctor, though aware of this coercion, performed it.[49] A leading Dutch practitioner of euthanasia even concedes that being "a nuisance to [one's] relatives," because those relatives want to enjoy the patient's estate, may be an acceptable circumstance for euthanasia.[50]

The 1994 television film, *Death by Request*, documented the euthanasia of a Dutch patient, Cees van Wendel, afflicted with amyotrophic lateral sclerosis (Lou Gehrig's disease). In the film, the patient's wife answers all questions, including those regarding whether her husband wants to die. The doctor at no time asks to speak to Cees alone; neither does he ask if anything would make it easier for him to communicate or if additional help in his care would make him want to live.[51] The film, clearly intended to demonstrate the compassionate aspect of euthanasia, instead illustrates the strong influence that families and physicians may have on the decisions of patients, and the inability of physicians, in an environment where euthanasia is accepted practice, to control for such factors.

---

[47] H.W. Hilhorst, *Euthanasie in het Ziekenhuis* [Euthanasia in the Hospital] (1983).

[48] Gomez, *supra* note 7 at 110.

[49] Hendin, *supra* note 14 at 93.

[50] Keown I, *supra* at 203 (interview with Dr. Herbert Cohen).

[51] Hendin, supra at 115.

Similar concerns are raised by the case of Dr. Boudewijn Chabot, the subject of a landmark decision by the Dutch Supreme Court. The pseudonymous victim, Netty, was divorced from an abusive husband and had lost both of her sons, the second two months earlier to cancer. She was referred to Dr. Chabot, a psychiatrist, by a euthanasia society. Dr. Chabot did not treat Netty as a patient, but after a two-month-long period of consultations, decided that her mental state could not improve and prescribed barbiturates for her to kill herself. Several psychiatrists who were consulted by Dr. Chabot (none of whom saw Netty personally) believed that assisting in her suicide was an appropriate course of action.[52] Netty was assisted in suicide by Dr. Chabot four months after the death of her second son.

In these cases, there was no objective assessment of factors influencing the patient's request for euthanasia. Moreover, the attitudes of the physicians clearly demonstrated the inappropriateness of relying upon their judgment to make such assessments. Netty's depression and bereavement, which were clearly the decisive factors in her suicide, were judged "untreatable" by Dr. Chabot after he accepted at face value her refusal of any and all attempts at treatment for depression. Even without treatment, time alone was likely to have affected her mood.

How suitable alternatives are presented to a patient is as important as whether they are presented at all. Cees van Wendel's physician betrayed his own stake in the patient's decision for suicide by the following statement: "[W]hat else can I offer the man? I can give him the finest wheelchair there is, but in the end

[52] The Dutch Supreme Court, which ruled on the Assen case in June 1994, affirmed lower court rulings that mental suffering can be grounds for assisted suicide, but it found Chabot guilty of not having had a psychiatric consultant see the patient. Although the court expressed the belief that such consultation was particularly necessary in the absence of physical illness, since it felt that in all other regards Chabot had behaved responsibly, it recommended no punishment. *Id.* at 64-69.

it is only a stopgap. He's going to die and he knows it."[53] Legal and professional guidelines did nothing to prevent these avoidable suicides.

IV. THE EXPERIENCE OF THE NETHERLANDS FURTHER DEMONSTRATES THE VIRTUAL IMPOSSIBILITY OF REGULATING PHYSICIAN-ASSISTED SUICIDE OR LIMITING IT TO COMPETENT, TERMINALLY ILL INDIVIDUALS.

As the cases previously discussed suggest, the history of euthanasia in the Netherlands is one of constant expansion from allegedly small beginnings. While this history was dismissed by the Ninth Circuit as irrelevant, 79 F.3d at 830, n. 114, the Supreme Court of Canada,[54] the Select Committee on Medical Ethics of the British House of Lords,[55] and the New York State Task Force[56] all considered it relevant to test the presumption that assisted suicide and euthanasia can be effectively limited through legal regulation. As these bodies concluded, the Netherlands experience demonstrates that this presumption is invalid.

A. Virtually Every Guideline Established by the Dutch to Regulate Euthanasia Is Routinely Violated in Practice.

According to guidelines issued by the Dutch minister for health, physicians will not be subject to prosecution under articles 293 and 294 of the Dutch penal code under the following conditions: (1) the request for euthanasia must come only from the patient and must be entirely free and voluntary; (2) the patient's request must be well considered, durable, and persistent; (3) the

[53] *Id.* at 119.

[54] Rodriguez v. Attorney General, 107 D.L.R.4th 347, 402-403 (Can. 1993).

[55] H.L. Rep. of the Select Comm. on Med. Ethics 28-29, 48 (1994).

[56] N.Y. State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 133 (1994).

patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement; (4) euthanasia must be a last resort, and other alternatives must have been considered and found wanting; (5) euthanasia must be performed by a physician; and (6) the physician must consult with an independent physician colleague who has experience in this field.[57] The guidelines also have required that cases of euthanasia be reflected as such on death certificates, and that all cases of euthanasia be reported to authorities.[58]

In practice, however, most of these guidelines are routinely violated. As discussed previously, the principle of voluntariness is compromised by the mental state that characterizes these patients, and the undue influence of physicians and family members. The criterion of "intolerable suffering" has been stretched, with the approval of the Dutch Supreme Court in the case of Dr. Chabot, to include cases where there is absolutely no physical illness and where the mental suffering itself might well have been treatable. The criterion of terminal illness was abandoned by the Dutch on the ground that cases of chronic illness could involve a situation of "necessity" equal to those of terminal illness. In general, the logic of permitting euthanasia in one set of circumstances inevitably leads to acceptance of euthanasia in other circumstances where the "equities" appear to be similar.[59]

Two guidelines intended to provide an independent "check" upon euthanasia practices are also frequently dishonored. The required consultation with a second physician is often *pro forma* and apparently has taken place without the second doctor

---

[57] Keown I, *supra* at 198-201.

[58] Note, *Court of the Hague (Penal Chamber) April 2, 1987*, 3 Issues in Law & Med. 451, 452 (1988); Keown I, *supra* at 198.

[59] Keown I, *supra* at 210-216. "[I]n instances in which the practice of euthanasia seemed to have gone beyond the generally assumed bounds, there was still an appeal to a more liberal interpretation of the criteria or an appeal to the exigencies of the particular case that, according to the narrator, excused him or her from following a particular guideline." Gomez, *supra* note 36 at 97.

personally seeing the patient.[60] The Van der Maas Survey revealed that consultation takes place in less than half of the cases where euthanasia is practiced without the explicit request of the patient,[61] and that a third of physicians do not consider the requirement to be important.[62] In addition, known euthanasia practitioners are likely to be called in to consult in such cases. Participation by such physicians is not likely to result in decisions not to perform euthanasia.[63]

The requirement that euthanasia be accurately reported on death certificates and subject to review by authorities is breached in the vast majority of cases. The Van der Maas Survey showed that 72 percent of deaths where euthanasia was performed in response to an explicit request by the patient were falsely reported as "natural deaths."[64] Virtually all cases where medical decisions to end life were taken *without* explicit request were reported as natural deaths and not reported to authorities.[65] This pattern of non-compliance has many consequences, not the least of which is to undermine the enforceability of any objective set of standards or guidelines:

> Apparently, many euthanasia advocates want to create their own guidelines, which they can do freely if they do not report their cases. The problem, therefore, is not simply a slippery slope on which legalization of euthanasia for one group of patients inevitably leads to legalization for others. Legalization for whatever group

---

[60] M.T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?*, 42 J. Am. Geriatrics Soc'y 624, 627 (1994).

[61] *Survey*, *supra* at 64.

[62] *Id.* at 96.

[63] Hendin, *supra* note 26 at 122-124.

[64] *Survey*, *supra* at 49, Table 5.14. Even after explicit statutory protection was given to Dutch physicians who follow the guidelines, 40 percent still reported euthanasia deaths as natural deaths. Hendin at 124.

[65] *Id.* at 65.

> happens to be first on the slope cannot be regulated. Only after guidelines have been stretched, ignored, or circumvented for some time does pressure develop to legalize what is already practiced.[66]

Another consequence is that it allows those who favor euthanasia to pretend that the practice in the Netherlands is well-controlled and not subject to abuse. According to one Dutch medical ethicist, "the majority of cases in which doctors intentionally shorten patients' lives, either by act or omission, remains unnotified, unchecked, and invisible to justice."[67]

B. Legalization of Euthanasia on Request Has Led in the Netherlands to Acceptance of Nonvoluntary Euthanasia.

The Van der Maas Survey reveals that the majority of medical decisions to end life take place without the specific request of the patient. According to the Survey's official summary, slightly under two percent (2300) of all deaths (approximately 130,000) in the Netherlands result from euthanasia administered to a person who has requested it; an additional 400 deaths (0.3 percent) resulted from assisted suicide.[68]

In contrast, many thousands more cases of intentional shortening of life by physicians do not involve an explicit request of the patient. The Survey reports that 1000 deaths (0.8 percent) occur in cases where "physicians prescribe, supply, or administer a drug with the explicit purpose of hastening the end of life without explicit request of the patient."[69] Twenty-seven percent of doctors indicated they had terminated the lives of patients without a request to do so; another 32 percent could conceive of doing so.[70]

---

[66] *Id.* at 124.

[67] Henk Jochemsen, *supra* note 37, at 215.

[68] *Survey*, *supra* at 178-179.

[69] *Id.* at 194.

[70] *Survey* at 58, Table 6.1.

According to the Survey other forms of hastening death without the patient's consent are common practice in the Netherlands as well. In over 5,000 of the 49,000 cases in which medical decisions were made at the end of life, the doctors' primary intention in administering pain medication or withdrawing or withholding treatment was to shorten life; in over 11,000 cases this was a secondary goal.[71] In about 25,000 cases decisions were made that might or were intended to end the lives of patients without consulting them.[72] In about 20,000 cases, physicians gave the patient's impaired ability to communicate as their justification for not seeking consent.[73] That left about 5,000 cases in which physicians made decisions that might or were intended to end the lives of competent patients without consulting them.[74]

In 13 percent of cases, physicians who did not communicate with competent patients concerning decisions that might or were intended to end their lives gave as the reason for doing so that they had previously had some discussion of the subject with the patient.[75] Yet it seems incomprehensible that a physician would terminate the life of a competent patient on the basis of some prior discussion without checking to see if the patient still felt the same way.

Conservatively speaking, it is clear that more euthanasia deaths occur in cases where patients have made no request to their physician to end their lives than in cases where patients have made such a request. That this should be is remarkable in light of the Dutch insistence that euthanasia be limited to cases of voluntary request. The summary of guidelines issued by the Dutch minister of health clearly indicated that the free, voluntary, and informed consent of the patient was the touchstone of legal toleration of euthanasia. No judicial decision has ever retracted this basic

---

[71] Keown II, *supra* at 269-270, Table 1.

[72] *Id.*, citing *Survey* at 133.

[73] *Id.* at 134.

[74] *Id.* at 75, Tables 7.7 and 8.7.

[75] *Id.* at 134, Table 13.5.

requirement.[76] Yet, the incidence of nonvoluntary euthanasia was apparently widespread at the time these guidelines were issued (the Survey was conducted in 1990), and is now defended in medical and official governmental circles. A government report issued in conjunction with the Van der Maas Survey referred to cases in which physicians had terminated the lives of patients without request as appropriate "care for the dying" and as part of normal medical practice.[77] The clear implication is that it is not patient consent, but "unbearable suffering," "low quality of life," poor prognosis for recovery, and the fact that the patient has "entered the dying phase of life" that form the real justification for tolerance of euthanasia.[78]

A number of Dutch euthanasia advocates have admitted that practicing euthanasia with legal sanction has encouraged doctors to feel that they can make life or death decisions without consulting even competent patients. To illustrate this point: in one case, a doctor terminated the life of a nun a few days before she would have died because she was in excruciating pain, and her religious convictions did not permit her to request euthanasia.[79] In cases such as these, "the patient has no autonomy because the

---

[76] In similar vein, the court of appeals has proposed that the "critical line" in cases involving both physician-assisted suicide and the forgoing of life-sustaining treatment is "the one between voluntary and involuntary termination of an individual's life." 79 F.3d at 832. Yet, the accompanying footnote clearly indicates that the line would be as movable under the logic of this decision as it has been in the Netherlands:

> While we place euthanasia, as we define it [ending a patient's life as an act of mercy, but not upon request], on the opposite side of the constitutional line we draw *for purposes of this case*, we do not intimate any view as to the constitutional or legal implications of the practice.

Id. at 832, n. 120 (emphasis supplied).

[77] Keown II, *supra* at 276-277.

[78] Hendin, *supra* note 26 at 89.

[79] *Id.* at 79.

doctor has decided that the quality of the patient's life is such that it is time for the patient to die.[80]

V. LEGAL SANCTION FOR EUTHANASIA HAS IMPAIRED THE TREATMENT OF DEPRESSED SUICIDAL PATIENTS IN THE NETHERLANDS AND WOULD DO SO IN THE UNITED STATES.

What happens in the Netherlands to patients who become suicidal in response to serious or terminal illness is illustrated by a case presented in a film, *An Appointment with Death*,[81] distributed by the Dutch Voluntary Euthanasia Society. Although the film was intended to promote euthanasia, it provides an example of how a physician's inability to deal with a patient's fear of death led to a premature ending of the patient's life.

A forty-one year old artist was diagnosed as HIV positive. He had no physical symptoms, but had seen others suffer with them and wanted his physician's assistance in dying. The doctor compassionately explained to him that he might live for some years symptom-free. Over time the patient repeatedly requested euthanasia and eventually his doctor acceded to it.

The man was clearly depressed and overwhelmed by the news of his situation. The doctor kept establishing that the patient was persistent in his request, but did not address the terror that underlay it.

Consultation in the case was pro forma. A colleague of the doctor's saw the patient briefly to confirm his wishes. With a psychologically sensitive physician able to deal with more than whether his patient meet criteria regarding his request to die, more likely in a culture not so accepting of euthanasia, this man would not have needed to be put to death.

The doctor thought his patient was acting unwisely and prematurely. Not knowing how to deal with his patient's terror, he

---

[80] *Id.* at 90.

[81] *An Appointment with Death*, K.A. Productions (1993).

rationalized that respect for the patient's autonomy required that he go forward.

This attitude, which was typical of Dutch doctors in dealing with patients who become suicidal in response to illness, has obviously had an impact on the treatment of suicidal patients in the Netherlands. In the past decade by making assisted suicide and euthanasia easily available, the Dutch have significantly reduced the suicide rate of those over fifty in the population. Comparing the five years of 1980-1984 with the 1988-1992 years provides statistically significant evidence of a drop in the older age group that is not due to chance.

This is the age group containing the highest numbers of euthanasia cases (86% of the men and 78% of the women) and the greatest number of suicides. The past decade is the period of growing Dutch acceptance of euthanasia. The remarkable drop in the older age group appears to be due to the fact that older suicidal patients are now asking to receive euthanasia. The likelihood that patients would end their own lives if euthanasia were not available to them was one of the justifications given by Dutch doctors for providing such help.

Of course, euthanasia advocates can maintain that making suicide "unnecessary" for those over fifty who are physically ill is a benefit of legalization rather than a sign of abuse. Such an attitude depends, of course, on whether one believes that there are alternatives to assisted suicide or euthanasia for dealing with the problems of older people who become ill.

In this country, as well as the Netherlands, among an older population physical illness of all types is common. Some who have trouble coping with physical illness became suicidal. In a culture accepting of euthanasia their distress is accepted as a legitimate reason for dying. It may be more than ironic to describe euthanasia as the Dutch cure for suicide.

What parallels do we already see or are we likely to see in the Dutch experience to our own? Our legal system as well as our medical and ethical values would make it difficult for use to make a distinction between assisted suicide and euthanasia. Nor if we

recognize a right to assisted suicide and or euthanasia would we find it easy to exclude people who are suffering but are not terminally ill.

The leading medical advocates of assisted suicide in the United States have authored model proposals that make clear that legalization of assisted suicide for terminally ill patients is but a first step. Timothy Quill and five co-authors, for example, call in the *New England Journal of Medicine* for legalization of euthanasia as well as assisted suicide not only for "competent patients suffering from terminal illness" but also for those with "incurable, debilitating disease who voluntarily request to end their lives" "Incurable debilitating disease" could include conditions like diabetes and arthritis.[82]

The Chabot case aroused such concern outside of the Netherlands that we are not likely to see pressure for assisted suicide or euthanasia for distress unaccompanied by physical illness for some time. Psychological distress, however, is most often at the basis of the request for assisted suicide even when the patient has a physical illness. If legalization occurs the combination of the two is as likely to be accepted as justification for euthanasia here as it is in the Netherlands.

There is every reason to believe that in this country just as in the Netherlands giving physicians the power to end life will encourage many to make such decisions without consulting patients. Some admit to having done so already.[83]

The American cases of assisted suicide published as models intended to persuade us of the benefits of legalization — such as Quill's Diane and Compassion in Dying's Louise — reveal the same problems as Dutch cases and indicate that American doctors are no different than Dutch doctors when deciding to utilize assisted suicide.

---

[82] F.G. Miller, et al. *Regulating Physician-Assisted Death*, 433 New Eng. J. Med. 119 (1994).

[83] Anon., *It's Over, Debbie*, 259 JAMA 272 (1988).

The public has the illusion that legalizing assisted suicide and euthanasia will give them greater autonomy. The Dutch experience teaches us that legal sanction for assisted suicide and euthanasia actually increases the power and control of doctors who can suggest or encourage it, not propose obvious alternatives, ignore patients' ambivalence about suicide, and even put to death patients who have not requested it.

Conclusion

For all the forgoing reasons, and for the reasons urged by the Petitioners and their *Amici* in the instant case and in *Quill* v. *Vacco* (No. 95-1858), the judgments of the Ninth and Second Circuits should be reversed and the complaints dismissed.

Respectfully submitted,

ELLEN H. MOSKOWITZ
Counsel of Record for Amicus Curiae
The American Suicide Foundation
255 Elm Road
Briarcliff Manor, NY 10510
(914) 762-8500

EDWARD S. GRANT
12780 Tuberville Lane
Herndon, VA 20171

JOHN F. CANNON
125 Broad Street
New York, NY 10004

Of Counsel

November 12, 1996